## WORKERS' COMPENSATION FRAUD & COMPLIANCE UNIT CLAIM REFERRAL / INITIAL INFORMATION REPORT

HOTLINE/PO BOX		INVESTIGATOR	DATE/TIME		
COMPLAINANT:				Phone:	
Address:					
Business	Name/Position: _				
SUBJECT:					
		WT:			
	Sex:	Mustache/Beard:			Hair:
	Age:	Scar/Tattoo:			Glasses:
VEHICLE #1:	Make/Yr:		Model:		
	Color:		Registration#: _		
ACTIVITY / ALL	EGATION:				
		(Continued on ba	ack)		

Submit to: Department of Labor & Training

**Workers' Compensation Fraud Unit** 

P O Box 20190

Cranston, RI 02920-0942

Hot Line: (401) 462-8100 (option #7) E-mail: wcfraud@dlt.state.ri.us

<u>CLAIMANT</u> :	DWC Claim No:	SSN:		
	Name:			
	Address:			
	City: Telephone:			
	Date of Injury:			
EMPLOYER:	Name:			
	Address:			
		Telephone:		
INSURANCE CO:	Name:			
	Telephone:	Extension:		
	Claim #:	Body Part(s):		
	Adjuster:	Extension:		
INCAPACITY:	1 <sup>st</sup> Incap. From: 2 <sup>nd</sup> Incap. From: 3 <sup>rd</sup> Incap. From:	To:		
INFORMATION:	Marital Status:	Dependents:		
	AWW:	Comp. Rate:		
<u>CLAIM STATUS</u> :	Open / Closed	Total/Partial:		
	Non-Pred/Date:	Term./Date:		
	MOA/Date:	Susp./Date:		
	Settlement/Date:	Decree (WCC#):		
DATE OF BIRTH:				
PREVIOUS INJURY: No / Yes	DOI:	Claim#:		
	DOI:	Claim#:		

## WORKERS' COMPENSATION FRAUD PREVENTION UNIT CLAIM REFERRAL / INITIAL INFORMATION REPORT

ACTIVITY/ALLEGATION - (Continued)				